TELEMEDICINE SERVICES AGREEMENT/CERTIFICATION

I, the undersigned participating physician/provider, agree to provide telemedicine services as described in the Physician chapter of the Alabama Medicaid Provider Manual and in accordance with the terms and conditions expressed in the Medicaid State Plan for Medical Assistance, the Administrative Code and all other federal and state laws and regulations as they pertain to my performance under this agreement.

In addition, I understand that the performance of this service must be documented, as all medical records pertaining to the Telemedicine Services Program are subject to audit by federal and state agency representatives.

Furthermore, I certify the following:
I have the ability to provide medically necessary services via an interactive audio and video telecommunications system which permits two-way communication between the distant site physician and the origination site where the recipient is located;

- The equipment used at the recipient site, and at the physician site is sufficient to allow the health care physician to appropriately evaluate, diagnose, or treat the recipient for services billed to Medicaid;
- **All** transmissions utilize an acceptable method of encryption;
- Written quality of care protocols are operational at this site where telemedicine services are provided;
- Recipient confidentiality protocols are operational at this site where telemedicine services are provided;
- A sample copy of the informed consent form is attached;
- The provider(s) listed below provide telemedicine services at this site; and

Provider Name	**NPI Number**	**Type of Service Provided**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- The authorized contact person and their telephone number for this site is:

_____
Contact's Name Contact's Phone Number

_____
Provider's Printed Name

_____
Physical Street Address
(Indicate address applicable to site of practice at which telemedicine services will be provided.)

_____
City, State and Zip Code +4

_____
NPI Number
(NPI number must be that of the enrollee and must be active.)

_____
Provider's Signature
(Original signature of the enrollee is required.)

_____
ATN (Application Tracking Number)

SAMPLE

ALABAMA MEDICAID TELEMEDICINE
RECIPIENT CONSENT FORM

I (name) _____ _____ agree to receive this health care service, (type of service) _____, as a telemedicine service. I understand that the health care practitioner (name) _____ is located in another location (facility name and address) _____ . A telemedicine service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for **six** months for follow-up telemedicine services with the health care provider, medical treatment, provider payment, and health care operations. The original document is retained in the medical record, and the recipient receives a copy.

I also understand that:

- I can decline the telemedicine service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the telemedicine service.
- If I decline the telemedicine services, the other options/alternatives available for me, including in person services, are as follows:

- The same confidentiality protections that apply to my other medical care also apply to the telemedicine service.
- I will have access to all medical information resulting from the telemedicine service as provided by law.
- The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my **additional** written consent.
- I will be informed of all people who will be present at all sites during my telemedicine service.
- I may exclude anyone from any site during my telehealth service.
- I may see an appropriately trained staff person or employee in-person immediately after the telemedicine service if an urgent need arises **OR** I will be told ahead of time that this is not available.
- I may contact the healthcare provider at phone number_____ for any questions I have related to medical services received through a telemedicine provider/site.

I have read this document carefully, and my questions have been answered to my satisfaction.

Signature of Recipient _____

Date_____

OR

Signature of Parent or Legal Representative _____

Date_____

Telemedicine Consent:

Signature of Person Obtaining Consent_____

Date_____

Facility Name_____

Facility Address_____